FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Bills Payment (Intermediary)

The following is a list of major activities related to Bills Payment. The Activity Codes listed below are also described in the Activity Dictionaries (Attachment 1 to the BPRs). However, these should not be construed as an all-inclusive list of tasks. Intermediaries should continue to budget for all activities currently performed, unless directed otherwise for specific tasks by CMS. If there is a significant activity that you perform that is not listed below or included in the Activity Dictionary for Bills Payment, please add a statement in your narrative justification describing that activity.

The Bills Payment BPRs for FY 2005 relates to CMS' goal to promote sound financial management and fiscal integrity of CMS programs.

Perform Electronic Data Interchange (EDI) Oversight (Activity Code 11201)

This activity includes establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic claim submission, electronic remittance advice, electronic claim status query, electronic eligibility query, and for other purposes as supported by direct data entry (DDE) screens and Medicare-supported formats for the electronic exchange of data; and/or between Medicare and a bank for electronic funds transfer. Successful operation of EDI entails establishment and maintenance of records to enable EDI to occur; support of providers, clearinghouses, software vendors, and other third party provider agents to assure continued submission and processing of compliant transactions; maintenance of connectivity; and detection and corrective action related to potential misuse of electronic transactions. The requirements for these activities are included in the following CRs, the Internal Only Manual (IOM), and Joint Signature Memos:

- IOM – Medicare Claims Processing Manual – Chapters 22, 24, 25, 26, and 31

- CRs amending the IOM:

  CR 2819 – Ch. 24/Section 40.7
  CR 2879 – Ch. 24/Section 40.1
  CR 2966 - Ch. 24/Section 90
  CR 3001 – Ch. 24/Section 40.7
  CR 3017 – Ch. 31/Section 20.7
  CR 3031 – Ch. 24/Section 70
  CR 3100 – Ch. 24/Section 70

- Joint Signature Memorandum (RO-2323, 10-29-03)

The tasks in this activity include:

a. Obtaining valid EDI and Electronic Funds Transferred (EFT) agreements, provider authorizations for third party representation for EDI, and network service vendor agreements. Entry of that data into the appropriate provider-specific and security files, and processing reported changes involving those agreements and authorizations;
b. Issuance, control, updating, and monitoring of system passwords and EDI claim submission/inquiry account numbers to control electronic access to beneficiary and provider data;
c. Sponsorship of providers and vendors for establishment of connectivity via IVANS, other private network connections or LU 6.2 connections, where supported, to enable the electronic exchange of data via DDE, if supported, and EDI;
d. System testing with electronic providers/agents as directed by CMS to assure compatibility between systems for the successful exchange of data;
e. Submission of EDI data, status reports on the progress of HIPAA transactions implementation, weekly reports on the progress of submitter testing, and other EDI status reports as directed by CMS;
f. Investigation of high provider eligibility query to claim ratios to detect potential misuse of eligibility queries, and taking corrective action as needed when problems are detected;
g. Monitoring and analysis of recurring EDI submission and receipt errors, and coordination with the submitters and receivers as necessary to eliminate the identified errors;
h. Maintenance of a list of software vendors whose EDI software has successfully tested for submission of transactions to Medicare;
i. Provision of customer support for the use of free/low cost billing software; and
j. Basic support of trading partners in the interpretation of transactions as issued by Medicare.

Manage Paper Bills/Claims and the Standard Paper Remittance (SPR) Advice Format (Activity Code 11202)

This activity includes all costs related to the receipt, control, and entry of paper claims (i.e., the UB-92/CMS-1450) and for maintenance of the SPR format, and as required by the IOM, Chapter 22/Section 50, and Chapter 25 including:

a. Opening, sorting, and distributing incoming claims including paper adjustment bills;
b. Assigning control number and date of receipt;
c. Imaging of paper claims and attachments;
d. Data entry (manual or optical character recognition scanning) of paper claim data, and re-entry of data for corrected/developed paper bills;
e. Identification of paper claims during the data entry process that cannot be processed due to incomplete information;
f. Resolution of certain front-end edits related to paper claims;
g. Return of incomplete paper claims, and paper claims that failed front-end edits to submitters for correction and resubmission;

h. Re-enter corrected/developed paper claims, managing paper bills and paper adjustment bills; and
i. Updating of the SPR once per year as directed by CMS to keep corresponding fields in the electronic and paper remittance advice formats in sync.

See the Productivity Investment (PI) section for information on additional activities planned for FY 2005. Do not include incremental costs for those PI activities in your estimates for this operational activity.

Workload

The paper bills workload (Workload 1) is the difference between the total claims reported on the CMS-1566, p.11, line 38, column 1, minus the EMC bills reported on line 38, column 8.

Manage EDI Bills/Claims and Related EDI Transactions (Activity 11203)

This activity includes establishment, maintenance, and operation of the EDI infrastructure to assure efficient operation of EDI processes that permit the fully automated transfer of data between a claim submitter (provider or agent) and Medicare. This includes costs related to your software, hardware, staff support, and other resources to enable electronic submission of claims, issuance of electronic remittance advice, electronic claim status inquiry and response, electronic eligibility inquiry and response, electronic funds transfer, and for other purposes as required for direct data entry (DDE); and/or between Medicare and a bank for electronic funds transfer, except as included in Activity Code 11201.

Medicare expects there will be a need to maintain up to two HIPAA formats at any given time: the current format, and a subsequent format during a transition period between them. Contractors must include in this ongoing activity estimated costs to implement an upgrade in FY 2005 of each implemented HIPAA transaction format, including any related adjustment to their translator and maps. Retesting of existing submitters are not expected to be required in conjunction with any such upgrades. In early FY 2005, however, it may be necessary to maintain both pre/non-HIPAA and HIPAA formats. As a result of the HIPAA contingency invoked by Medicare and most other covered entities, Medicare contractors will be required to continue to support the pre/non-HIPAA formats/versions until directed by CMS to eliminate their support.

Although no version upgrade is expected to be adopted under HIPAA in FY 2005, it is possible that errors could be detected during submitter testing that could identify the need for further modification of flat files used by Medicare to support the HIPAA formats. The FY 2005 upgrade would be related to such changes.

Requirements under this activity are included in the following CRs, companion documents, and chapters of the IOM including:

- IOM – Medicare Claims Processing Manual – Chapters 22, 24, 25, 26, and 31

- CR 2947/835 Companion Document and Flat File Modification
  CR 2948/835 Companion Document Modification
  CR 3050/Ch. 24/Section 40.7.2
  CR 3065/Ch. 31

- Companion Documents and Flat Files for 837I, 835, and 276/277 as published at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp

This activity must exclude costs for:

- Any share of the costs of a clearinghouse or other service organization established by an umbrella organization which owns or has a contractual relationship with a Medicare intermediary;

- Any costs for activities not specifically permitted by CMS for EDI; and

- Costs that exceed Medicare's pro-rata share of the indirect, general and administrative EDI costs related to overhead shared with any parent company of a Medicare intermediary.

See the Productivity Investment (PI) section for information on subsequent instructions planned for FY 2005 implementation. Do not include incremental costs for those PI activities in your estimates for this operational activity.

The tasks in this activity include:

a. Provision of free billing and PC-Print software to providers/agents on their request, and upgrading of that software once per year, if so directed by CMS;
b. Maintenance, if applicable, and Alpha testing and validation of free billing software prior to issuance to providers/agents;
c. Resolution of problems with telecommunication protocols and lines, software and hardware to support connections to enable providers/agents to electronically send/receive data for EDI transactions in a secure manner;
d. Maintenance of capability for receipt and issuance of transactions via direct data entry (DDE), and via electronic transmission of transactions in batches;
e. Maintenance of EDI access, syntax and semantic edits at the front-end, prior to shared system processing;
f. Routing of electronic edit and exception messages, electronic claim acknowledgements, electronic claim development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic mailbox for downloading by the trading partners, and routing of electronic funds transfers (EFT);
g. Maintenance of back end edits to assure that outgoing electronic remittance advice 835 and 277 response transactions comply with the applicable implementation guide requirements, and that ACH EFT transactions comply with those separate requirements;

h. Creation and retention of a copy of each EDI claim and submitted adjusted claims as received and the ability to recreate each 835 and 837 COB transaction as issued;
i. Maintenance of audit trails to document processing of EDI transactions;
j. Translation of transaction data between the pre-HIPAA and HIPAA standard formats and the corresponding internal flat files used in the shared system;
k. Updating of claim status and category codes, claim adjustment reason codes, remittance advice remark codes, and taxonomy codes three times a year per the updating schedule as directed by CMS; and
l. Billing of third parties as directed by CMS for access to beneficiary eligibility data, maintaining receivables for those accounts, and terminating third parties if warranted due to non-payment.

Workload

The EDI claims workload (Workload 1) is reported on the CMS-1565, Page 9, Line 38, Column 6.

Bills/Claims Determination (Activity Code 11204)

After the bills are entered, and the initial edits applied, contractors must determine whether or not to pay a bill. Most of this process is fully automated with the costs included in the Run Systems Activity Code. However, technical staffs are also required to support bills pricing, adjudication, and payment in conjunction with the programming activities included in Run Systems. Specifically, contractors must create, maintain, and oversee fee schedules and other pricing determination processes (e.g., annual ICD-9 updates), including the following:

- Validity, consistency, eligibility, and duplicate detection checks on each bill;
- Re-entry of corrected/developed data for bills that suspend from the standard system;
- Payment method and payment rates are obtained for each provider file. If applicable, the PIP indicator is set. For PPS claims, the appropriate GROUPER is called and the output is forwarded to Pricer. For other PPS claims, appropriate fee schedules and pricers are used; and
- Payment amounts are calculated.

Workload

The adjudicated bills workload (Workload 1) is the cumulative number of bills processed as reported on the CMS-1566, Page 1, Line 12, Column 1.

Run Systems (Activity Code 11205)

This activity includes the costs of the programmer/management staff time and procurements associated with the systems support of bills processing. This activity also includes the local systems costs related to bills processing, as well as charges from the data center to the contractor to support its processing of the standard system. Other costs include (but are not limited to) local CPU costs, depreciation costs or lease of CPU; software/hardware costs; maintaining interfaces and data exchanges with standard systems, CWF, HDC, and State Medicaid Agencies; maintaining the print mail function; on-line systems; costs associated with testing of releases; and change requests. Also included are ongoing costs for LAN/WAN support and costs of transmitting data to and from the CWF hosts.

Note: All bills processing systems costs should be charged to 11205 including the application of MIP edits. However, the personnel costs associated with installing and activating the edits, and the staff resolution of bills that fail the edits should be charged to the function with ownership of the edits. Also, other systems related items such as personal computers or computer peripherals should be directly charged to the areas that use them.

Manage Information Systems Security Program (Activity Code 11206)

The Systems Security BPRs for FY 2005 relate to CMS' goals to promote the fiscal integrity of CMS programs and enhance program safeguards.

Principal Systems Security Officer (SSO)

Include the cost for appointing a principal SSO and staff responsible for managing a Medicare systems security program. This cost must include the cost of the Principal SSO earning 40 hours of continuing professional education credits from a recognized national information systems security organization. This cost must also include the cost of participating in the CMS Systems Security Technical Advisory Group (if requested by CMS), and CMS systems security best practice conferences. (Refer to Section 2.2 of the CMS Business Partner Systems Security Manual.)

Systems Security Self-Assessment using the Contractor Assessment Security Tool (CAST)

Include the cost of conducting the annual assessment of the CMS Business Partner Systems Security Manual.

Risk Assessment

Include the cost of reviewing and updating the annual risk assessment in accordance with the Business Partner System Security Manual and the CMS Information Security RA Methodology which is available at the following CMS website: http://www.cms.hhs.gov/it/security. (Refer to Section 3.2 of the CMS Business Partner Systems Security Manual.)

Systems Security Plans

Include the cost of developing an initial systems security plan or, if previously developed, the cost to review the SSP to determine if changes have occurred and requires the current SSP to be updated. Business partners are required to develop and certify an SSP in accordance with the CMS System Security Methodology. (Refer to Section 3.1 of the CMS Business Partner System Security Manual.)

Systems Security Certification

Include the cost of preparing the systems security portion of the annual internal control certification. The certification documents that the Security Self-Assessment, Risk Assessment, Business Continuity and Contingency Plan, System Security Plan, Annual Compliance Audit and Correction Action Plan are in compliance with the CMS Business Partner Systems Security Manual. (Refer to Section 3.3 of the CMS Business Partner Systems Security Manual.) Note: Based on findings from the FY 2003 CFO EDP audits and requirements for system certification, particular attention should be directed to configuration management planning and procedures, and auditing and logging. These areas should be reviewed for compliance, as they will be among the focus areas reviewed and tested under CMS's FY 2005 Certification and Accreditation program. See Sections 3.6.1 and 4.7 of CMS' SSP Methodology.

Information Technology Systems Contingency Plan

Include the cost of conducting a review of the Information Technology Systems Contingency Plan annually to determine if an update is necessary or whenever a significant change to the system has occurred. Also include the annual cost of testing the plan. (Refer to Section 3.4 and Appendix B of the CMS Business Partner Systems Security Manual.)

Annual Compliance Audit

Include the cost of conducting an annual compliance audit of designated CMS Core Security Requirements. (Refer to Section 3.5.1 of the CMS Business Partner Systems Security Manual.)

Corrective Action Plan

Include the cost of preparing and managing a corrective action plan to address weaknesses identified as a result of audits and evaluations including the CFO EDP audit, SAS-70 reviews, self-assessments and the Annual Compliance Audit. (Refer to Section 3.5.2 of the CMS Business Partner Systems Security Manual.)

Incident Reporting and Response

Include the cost of analyzing and reporting systems security incidents, violation of security policy and procedures, to CMS and other appropriate officials. (Refer to Section 3.6 of the CMS

Business Partner Systems Security Manual.)

Systems Security Profile

Include the cost of collecting and maintaining all systems security files and documentation in appropriate on-site and off-site storage. (Refer to Section 3.7 of the CMS Business Partner Systems Security Manual.)

Perform Coordination of Benefits Activities with the Coordination of Benefits Contractor (COBC), Supplemental Payers, and States – Activity Code 11207

Reference: Pub 100-04, Section 70.6, Chapter 28.

Until CMS completes the transition of existing COB trading partners to national Coordination of Benefit Agreements (COBAs), contractors will maintain and support existing crossover Trading Partner Agreements (TPAs). When COB trading partners are fully transitioned to national COBAs, Medicare intermediaries will no longer be responsible for receiving eligibility files, applying claims selection criteria, sending outbound crossover claims file, and the invoicing/collecting/reconciling of claims crossover fees for TPAs. Tasks that are to be performed during the transition period from existing TPAs to national COBAs include all of the following:

For planning purposes, Medicare intermediaries should assume that all trading partners would be transitioned from existing TPAs to national COBAs by April 30, 2005.

- Perform the functions necessary to maintain and support existing TPAs.

- Perform the functions necessary to maintain and support COBAs by coordinating with the COBC to ensure that flat file transmission issues, including transmission problems, data quality problems, and other technical difficulties are resolved timely.

NOTE: Intermediaries will receive crossover fees for claims that are successfully transmitted to both the Coordination of Benefits contractor and the COBA trading partner. Intermediaries will receive the current fees set by CMS less $0.02 per claim in FY 2005.

For planning purposes, Medicare intermediaries should assume that CMS will implement a COBA recovery process that will require Medicare intermediaries to submit previously processed claims via a flat file to the COBC following receipt of a mini-eligibility file from the COBC that identifies specific beneficiaries, claims and time periods. The recovery process will be implemented no sooner than July 1, 2005. CMS will issue a Program Transmittal with instructions to:

- Perform the functions necessary to maintain and support the COBA recovery process to ensure COBA trading partner requests for retrospective Medicare claims are processed timely and by coordinating with the COBC to ensure that flat file transmission issues,

including transmission problems, data quality problems, and other technical difficulties are resolved timely.

NOTE: For all functions listed above, the following related activities should be charged appropriately as indicated.

1. Collection/invoicing/reconciliation of TPA and COBA crossover fees - Financial Management Overhead
2. Systems automation that currently exists for the TPA claims crossover process and that will exist as part of the COBA claims crossover processes - Run Systems
3. All TPA and COBA inquiries other than technical inquiries from existing trading partners or the COBC - Inquiries

Workload

Workload 1 is the number of claims transferred as designated in Pub. 100-06. (Currently only reported on the FACP.)

Workload 2 is the number of claims crossed to the COBC.

Conduct Quality Assurance (Activity Code 11208)

Include costs related to routine quality control techniques used by management to measure the competency and performance of bill processing personnel; quality assurance reviews of fee schedules, HCPCS, and ICD-9 updates and maintenance; and reviews of contractor systems.

Narrative Requirements

Briefly describe the internal quality assurance review of bills/claims processing. Describe the universe used, how bills/claims are selected, and whether the review is focused with specific criteria (such as new employee, new edits, etc.). Provide the number of MSNs reviewed, the average time spent per review, and the average cost per MSN reviewed to support the amount requested for internal reviews.

Also describe with the same information, activities/reviews that are not solely related to bills/claims review. In addition, describe how the results of the reviews are used in your operation.

Manage Outgoing Mail (Activity Code 11209)

This activity includes the costs to manage the outgoing mail operations for the bills processing function, e.g., costs for postage, printing Notice of Utilization (NOUs)/Medicare Summary Notice (MSNs)/Explanation of Medicare Benefits (EOMBs)/remittance advice notices and checks, and paper stock. This includes the following tasks:

a. Mail NOUs/MSNs/EOMBs, remittance advice notices and checks;
b. Mail requests for information (other than for medical records or MSP) to complete claims adjudication;
c. Return unprocessable claims to providers;
d. Return misdirected claims, e.g., back to providers; and
e. Forward misdirected mail, e.g., to another contractor where required by CMS.

The paper remittance advice notice instructions are contained in the MIM Part 3, Sections 3602.5, .7 and 3750, Program Memoranda A-00-23, A-00-36, AB-00-65, A-00-98, A-01-57/CR1522, AB-01-124/CR1802, as part of instructions issued for implementation of Outpatient, SNF and HHA PPS, and in CR 1959 currently being cleared for release in FY 2002. Remittance advice reason and remark codes are contained at www.wpc-edi.com and included by reference in a number of the listed remittance advice MIM and PM instructions. Paper check instructions are contained in the MIM Part 3, Section 3703. *Note: Do not include postage costs identified with other contractor operations (e.g., Medical Review, MSP, Inquiries, etc.). Also, the front-end mailroom costs of sorting incoming mail should be treated as overhead.*

Reopen Bills/Claims (Activity Code 11210)

Include all costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error; error on the face of the evidence; inaccurate coding; input error; or the misapplication of reasonable charge profiles and screens, etc. Refer to the IOM 100-4, Chapter 29, Section 60.27 for a comprehensive definition of what constitutes a reopening.

Note: Include the cost of processing an adjustment, but only if the adjustment is specifically related to a reopening. Do not include the cost of an adjustment to a claim that results from an appeal decision.

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Appeals/Hearings (Intermediary)

The Medicare Appeals and Hearings function ensures that the due process rights of beneficiaries and providers who are dissatisfied with initial claims determinations and subsequent appeal decisions are protected under the Medicare program. These BPRs are designed to provide continued support and guidance to the Medicare contractors as they focus their efforts on efficiently and effectively administering all levels of the Part A and Part B appeals processes.

In keeping with CMS' Strategic Plan Objectives, the appeals and hearings function is focused on improving beneficiary satisfaction with programs and services, increasing the usefulness of communications, and maintaining and improving CMS' position as a prudent program administrator and an accountable steward of public funds. We must also comply with statutory requirements regarding the processing of appeal requests in a cost-effective manner that supports our goals of customer service and fiscal responsibility.

In FY 2005, contractors should continue with the following objectives:

- Ensure that all appeals decisions are processed accurately and correctly;
- Process reconsiderations, reviews, and hearing officer hearings in accordance with the statutory timeliness standards;
- Complete redeterminations accurately, and in accordance with statutorily mandated timeframes;
- Prepare customer friendly written correspondence in accordance with the Internet Only Manual (IOM) Publication 100-4, Chapter 29, Sections 40 (Part A), 50 (B of A);
- Maintain complete and accurate case files;
- If necessary, prioritize workload in accordance with CR 2811 or the most current program guidance;
- Establish and maintain open communication with other program areas that impact appeals;
- Continue quality improvement and data analysis activities as described in your plan. Monitor and track significant changes in appeals receipts; and, identify root causes, anticipated duration, and necessary actions for countering any workload aberrancies; and
- Identify and refer providers that would benefit from education on the importance of submitting requests for appeals correctly, including applicable documentation at the earliest point in the appeals process.

In FY 2005, CMS expects that contractors will establish workload strategies and priorities within the budget provided. As a reminder, in addition to satisfying all requirements contained in the BPRs, Intermediaries are responsible for meeting the requirements of Chapter 29,

Sections 40 and 50 of the IOM, along with any relevant Change Requests, and should develop their FY 2005 budget requests accordingly. Also see the Activity Dictionary (Attachment 1 to the BPRs).

Capturing Workload

Intermediaries will continue to report appeals cost data on the CAFM II system. For each activity, Workload 1 is the number of claims processed and Workload 2 is the number of cases processed, unless otherwise noted. Workload 3 is the number of reversals at the given level of appeal, unless otherwise noted. If the workload is currently captured in CROWD, CAFM II will transfer this data into the appropriate Activity Code. Please refer to the workload chart included in this section of the BPRs for a description of workload for each Activity Code.

Changes in FY 2005

CMS plans to implement changes to the first level of appeal, previously called reconsiderations and reviews. For appeals received on or after October 1, 2004, the first level of appeal will be called redeterminations. Please refer to Change Request 2620 for more information. Costs associated with redeterminations should be captured similar to the way costs of reconsiderations and reviews have been captured in previous fiscal years. Appeal requests received prior to October 1, 2004 should be processed using the current manual instructions for reconsiderations and reviews including the timeliness standards for completion. There is no change in the way these costs are reported.

CMS anticipates phasing in reconsiderations by Qualified Independent Contractors (QICs) during FY 2005. (It is important to note that the reconsiderations that will be processed by QICs are different from the first level of appeal (reconsiderations) processed by intermediaries.) The schedule for this is not definite. As more information becomes available, additional guidance with respect to the BPRs will be provided. Intermediaries should budget to conduct hearing officer hearings for all of FY 2005.

Preparing and Submitting the Appeals and Hearings Budget Request

Intermediaries must submit narrative justifications supporting their appeals budget request. As part of the justification, include the following:

- Identify current trends, program initiatives, or other program requirements that could impact the volume of appeal receipts. Explain how the initiative/requirement will impact your appeals function and any additional cost you believe will be incurred in the appeals area.

APPEALS AND HEARINGS DELIVERABLES

Reports	*Submit to*
1.) Any revisions to your Appeals QI/DA Plan. If there are significant and/or numerous changes, submit a revised QI/DA report in its entirety. 2.) At least 3 QI/DA Reports per year	Regional Office to: RO Appeals Contact Central Office to: AppealsOperations@cms.hhs.gov

Descriptions of FY 2005 Intermediary Appeals Activities:

A general description of each activity is listed below. Please refer to IOM 100-4, 29, Sections 40 and 50 and applicable Program Memoranda for guidance in carrying out current appeals process activities.

Parts A and B Quality Improvement/Data Analysis (Activity Code 12090) (CR_2854 or AB-03-139, which will be updated for FY 2005)

Report all costs associated with conducting a quality improvement/data analysis program focused on reducing unnecessary appeals and improving performance requirements.

Part A Reconsiderations/Redeterminations (Activity Code 12110) (§§1869 and 1816(f)(2)(A)(i) of the Social Security Act; §§ IOM 100-4, Claims Processing Manual, Chapter 29, §§ 40.2, 40.3 and 40.4; § 521 of the Benefits Improvement and Protection Act of 2000; §§ 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003; CR 2620)

Report all costs and workloads associated with processing reconsiderations/redeterminations. Seventy-five percent of reconsiderations must be processed within 60 days and 90 percent must be processed within 90 days. All redeterminations must be processed and mailed within 60 days of receipt.

Incomplete Reconsideration/Redetermination Requests (Activity Code 12113) (IOM 100-4, Claims Processing Manual, Chapter 29, § 40.2; CR 2620)

Report all costs and workloads associated with returning incomplete and unclear requests for reconsiderations/redeterminations to the provider or State Medicaid Agency. Do not count these as dismissals or completed reconsiderations/redeterminations.

Part A Administrative Law Judge (ALJ) Hearing Requests (Activity Code 12120) (§§1869 and 1816(f)(2)(A)(ii) of the Social Security Act; IOM 100-4, Claims Processing Manual, Chapter 29, §§ 40.5, 40.6, 40.7, 50.7)

Report all costs and workloads associated with processing Part A ALJ Hearing Requests. Report all costs associated with effectuating Part A ALJ decisions. Report all costs and workload associated with referring Part A ALJ cases to the Departmental Appeals Board (DAB) also known as the appeals council (AC); responding to DAB requests for case files and effectuating DAB decisions.

- **Part A ALJ Courier Service (Miscellaneous Code 12120-01) (AB-03-144)**

  Report all costs associated with using the courier service to send ALJ case files to the appropriate Office of Hearings and Appeals.

Part B Telephone Reviews/Redeterminations (Activity Code 12141)

Intermediaries who perform Part B telephone reviews/redeterminations should report the applicable costs and workload here. Telephone reviews/redeterminations are reviews/redeterminations requested by phone and completed by phone.

- **Part B Telephone Review/Redetermination Dismissals and Withdrawals (Miscellaneous Code 12141/01)**

  Report costs associated with Part B Telephone Reviews/Redeterminations that are dismissed or withdrawn.

Part B Written Reviews/Redeterminations (Activity Code 12142) (§1842(b)(2)(B)(i) of the Social Security Act; IOM § 50.3; § 521 of the Benefits Improvement and Protection Act of 2000; §§ 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003; CR 2620)

Report all costs and workload associated with processing written review/redetermination requests. At least 95 percent of Part B reviews must be completed within 45 days of receipt. All redeterminations must be processed and mailed within 60 days of receipt. Written reviews/redeterminations are those reviews/redeterminations that are requested by phone or in writing and completed in writing.

- **Part B Written Review/Redetermination Dismissals and Withdrawals (Miscellaneous Code 12142/01)**

  Report costs associated with Part B written reviews/redeterminations that are dismissed or withdrawn.

Part B Incomplete Review/Redetermination Requests (Activity Code 12143) (IOM 100-4,

Claims Processing Manual, Chapter 29, § 50.3; CR 2620)

Report all costs and workloads associated with review/redetermination requests that are incomplete and, therefore, returned to the provider or State Medicaid agency. Do not count cost or workload associated with dismissals or completed reviews/redeterminations here.

Part B Hearing Officer (HO) Hearings (Activity Code 12150) (IOM 100-4, Claims Processing Manual, Chapter 29, § 50.4;
§1842 (b)2(B)(ii) of the Act)

Report all costs and workload associated with processing HO hearings. Include on-the-record, telephone and in-person hearings, and dismissals/withdrawals. At least 90 percent of all HO hearing decisions must be completed within 120 days of receipt of the request for the hearing.

Part B ALJ Hearings (Activity Code 12160) (IOM 100-4, Claims Processing Manual, Chapter 29, § 50.7)

Report all costs and workloads associated with processing Part B ALJ Hearing Requests. Report all costs associated with effectuating Part B ALJ decisions. Report all costs and workload associated with referring Part B ALJ cases to the Departmental Appeals Board (DAB) also known as the appeals council (AC); responding to DAB requests for case files and effectuating DAB decisions.

- **Part B ALJ Courier Service (Miscellaneous Code 12160-01) (AB-03-144)**

  Report all costs associated with using a courier mail service to send ALJ case files to the Office of Hearings and Appeals in Falls Church, Virginia.

PM COMPREHENSIVE ERROR RATE TESTING (CERT) SUPPORT

For FY 2005, CMS will provide funding earmarked for the Intermediaries to support the CERT contractor. CMS will provide a set amount of funding to each contractor. The PM CERT Support funding is over-and-above the level of funding provided to perform the Appeals activities listed earlier in this BPR. Intermediaries shall not shift additional funds from Appeals activities to this activity.

Do not include the costs associated with PM CERT support activities in any other function/activity code (i.e. Appeals, Bills Processing, Provider Communications, etc.). For example, contractors should not double count CERT appeals costs by including the cost of CERT appeals in both the regular Appeals activity codes and again in the PM CERT Support activity code. All costs related to any PM CERT support activity (whether an Appeals or any other PM costs) should be included in Activity Code 12901.

In addition to satisfying all requirements contained in the PM CERT Support section of the Appeals BPR, Intermediaries shall carry out all PM CERT Support activities identified in

Pub.100-8, Chapter 12 and all relevant PM CERT Support One Time Notifications.

PM CERT Support (Activity Code 12901)

Report the costs associated with time spent on PM CERT Support Activities. These activities include but are not limited to the following:

- Providing sample information to the CERT Contractor as described in Pub 100-8, Chapter 12, §3.3.1A&B.

- Ensuring that the correct provider address is supplied to the CERT Contractor as described in Pub 100-8, Chapter12, §3.3.1.C.

- Researching 'no resolution' cases as described in Pub 100-8, Chapter 12, §3.3.1.B.

- Handling and tracking CERT-initiated overpayments/underpayments as described in Pub 100-8, Chapter 12, §§3.4 and 3.6.1.

- Handling and tracking appeals of CERT-initiated denials as described in PUB 100-8, Chapter12, §§3.5 and 3.6.2.

Workload

For FY 2005, there are no CAFM II workload reporting requirements associated with Activity Code 12901.

Intermediaries shall NOT report costs associated with the following MIP CERT Support activities in this activity code:

- Providing review information to the CERT Contractor as described in Pub. 100-8, Chapter12, §3.3.2 (These costs should be allocated to the MIP CERT Support Code – 21901 as described in the MR BPR.)

- Providing feedback information to the CERT Contractor as described in Pub.100-8, Chapter12, §3.3.3 including but not limited to:

    - CMD discussions about CERT findings
    - Participation in biweekly CERT conference calls
    - Responding to inquiries from the CERT contractor
    - Preparing dispute cases

(These costs should be allocated to the MIP CERT Support Code – 21901 as described in the MR BPR)

- Preparing the Error Rate Reduction Plan (ERRP) as described in Pub 100-8, Chapter 12, *§3.9.* (These costs should be allocated to the MIP CERT Support Code – 21901 as described in the MR BPR.)

- Educating the provider community about CERT as described in Pub 100-8, Chapter 12, *§3.8.* (These costs should be allocated to the MIP CERT Support Code – 21901 as described in the MR BPR.)

- Contacting non-responders and referring recalcitrant non-responders to the OIG as described in Pub100-8, Chapter 12, §3.15. (These costs should be allocated to the MIP CERT Support Code – 21901 as described in the MR BPR.)

SUMMARY OF APPEALS CAFM II ACTIVITY CODE DEFINITIONS FOR INTERIM EXPENDITURE REPORTS- (Intermediary Part A and Part B)

Activity Code	Activity	Workload 1	Workload 2	Workload 3
12090	**Part A and B Quality Improvement/Data Analysis**	NA	NA	NA
12110	**Part A Reconsiderations/ Redeterminations**	Reconsideration/ Redetermination Requests Cleared (claims)	Reconsideration/ Redetermination Requests Cleared (cases)	Reconsideration/ Redetermination Requests Reversed (cases)
12113	**Part A Incomplete Reconsideration/ Redetermination Requests**	NA	Incomplete Reconsideration/ Redetermination Requests (cases)	NA
12120	**Part A ALJ Hearing Requests and Effectuations and DAB Referrals, Requests for Case Files and Effectuations**	Part A ALJ Hearing Requests Forwarded (claims)	Part A ALJ Hearing Requests Forwarded (cases)	Part A ALJ Hearings Effectuated (cases)
12120/01	**Courier Service Fee**	NA	NA	NA
12141/01	**Dismissals/Withdrawals of Part B Telephone Reviews/ Redeterminations**	NA	Telephone Review/ Redetermination Requests Dismissed or Withdrawn (Cases)	NA
12142	**Part B Written Reviews/ Redeterminations**	Written Review/ Redetermination Requests Cleared (claims)	Written Review/ Redetermination Requests Cleared (cases)	Written Review/ Redetermination Request Reversals (cases)
12142/01	**Dismissals/Withdrawals of Part B Written Reviews/ Redeterminations**	NA	Written Review/ Redetermination Requests Dismissed or Withdrawn (Cases)	NA
12143	**Part B Incomplete Review/ Redetermination Requests**	NA	Incomplete Review/ Redetermination Requests Received (cases)	NA
12150	**Part B Hearing Officer Hearings**	HO Hearings Cleared (claims)	HO Hearings Cleared (cases)	HO Hearings Reversed (cases)
12160	**Part B ALJ Hearing Requests and Effectuations and DAB Referrals, Requests for Case Files, and Effectuations**	Part B ALJ Hearing Requests Forwarded (claims)	Part B ALJ Hearing Requests Forwarded (cases)	Part B ALJ Hearings Effectuated (cases)
12160/01	**Courier Service Fee**	NA	NA	NA
12901	**PM CERT Support**	NA	NA	NA

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Beneficiary Inquiries (Intermediary)

As a customer-centered organization, CMS is focusing on providing improved service to all customers, including Medicare beneficiaries. The FY 2005 Beneficiary Inquiry BPRs are designed to encompass CMS' Strategic Plan and facilitate continuously improving customer service. CMS requests that each Medicare contractor prioritize its workload in such a manner to ensure that funding is allocated to accomplish the priority goals of the listed activities. CMS expects that each Medicare contractor meet standards for inquiry workloads in the following order of precedence:

1) Beneficiary Telephone Inquiries (including Quality Call Monitoring and the Next Generation Desktop);
2) Screening of complaints alleging fraud and abuse;
3) Written Inquiries, and
4) Beneficiary Outreach to improve Medicare customer service (Customer Service Plans).

All resources should be devoted to performing only these activities.

Any contractor call center upgrades or initiatives for purchases or developmental costs of hardware, software or other telecommunications technology that equal or exceed $10,000 must first be approved by CMS. Contractors shall submit all such requests to the servicing CMS regional office (RO) for review. The RO shall forward all recommendations for approval to the Center for Beneficiary Choices, Division of Contractor Beneficiary Services (DCBS), for a final decision.

In late FY 2004, CMS will migrate all current toll-free Medicare contractors' beneficiary telephone numbers to the standard 1-800-Medicare (1-800-633-4227) number. Beneficiary inquiries regarding specific claims and detailed coverage information will be automatically routed to the appropriate Medicare contractor's call center for response. CMS fully expects this migration to 1-800-Medicare to reduce the beneficiary call volumes for the Medicare contractors in FY 2005 and therefore will establish reduced beneficiary telephone inquiry budgets and workload estimates. The initial targets that CMS has established in FY 2005 reflect a 10% reduction in beneficiary telephone inquiries for most contractors. You should begin workforce planning to take reduced budgets and workload estimates into account, such as not filling vacancies and using attrition to reduce staff.

Because contractors' beneficiary telephone workloads and budgets will be reduced in FY 2005, CMS again this year strongly encourages any call center to volunteer to release their beneficiary telephone workload to another call center operation. Contractors who volunteer to release telephone workload will be allowed sufficient time (to be agreed upon by CMS and the contractor) to transition their beneficiary call center staff into other areas based on normal

turnover and not experience a mandatory reduction in force. Those contractors willing to release beneficiary telephone workload in FY 2005 should notify the Director, Division of Contractor Beneficiary Services, in the Center for Beneficiary Choices, as soon as possible.

Beneficiary Telephone Inquiries (Activity Code 13005)

The instructions for beneficiary telephone inquiries are described in Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2 - Beneficiary Customer Services, Section 20.1 – Guidelines for Telephone Service. Also refer to the Activity Dictionary (Attachment 1 to the BPRs) for the lists of tasks for this activity.

Please note the following additions/revisions to the current telephone manual instructions.

1. Next Generation Desktop (NGD)

a. Those contractors who will be deploying NGD in FY 2005 must include NGD implementation costs in their FY 2005 budget request in Activity Code 13005. These costs shall also be reported using Miscellaneous Code 13005/01 so that they can be identified separately as NGD implementation costs.

b. CMS is standardizing some of the business processes for the users of NGD to facilitate consistent customer service performance, reporting and training. Standardized NGD business procedures will be posted on the Medicare Beneficiary Telephone Customer Service website, http://www.cms.hhs.gov/callcenters/. Contractors using NGD are required to train and use these procedures within 30 days of posting. Contractors should access the website monthly for updates. Training for the standard procedures is being developed by CMS and will be distributed to the contractors as developed. The training will be incorporated into the CMS NGD training package on a quarterly basis.

c. A Deployment Assistance Center (DAC) has been established to support call centers during NGD implementation. The DAC is staffed with Customer Service Representatives (CSRs) trained to handle Medicare inquiries from all lines of business. Certain functions may need to be transferred back to the site, however, it is expected the sites deploying NGD will utilize the services provided by the DAC prior to requesting any performance waivers. During the period of implementation, CMS will work with the contractor to determine the support needed from the DAC and relax performance standards where it is still deemed appropriate.

d. Local Site Administration - Several administrative functions will be performed at the call center level by contractor personnel. Two to three days of mandatory training on these functions will be provided by NGD trainers at a central location.

e. Each contractor will be expected to operate a local help desk (Tier One) for NGD. The NGD trainers will provide a two-day training course for helpdesk personnel at a central location.

f. Security and Connectivity Issues: Technical Kick-off Meeting - Contractors deploying NGD will be required to send technical representation to a two-day technical kick-off meeting conducted by NGD infrastructure personnel in a central location. This meeting will take place prior to beginning the project plan to deploy NGD. Once all needed connectivity is obtained, an official deployment kickoff meeting will take place to begin the rollout of NGD to the contractor location(s).

g. Mercury Topaz - Mercury Topaz will be installed on one Personal Computer (PC) at each call center location prior to the rollout of NGD. Mercury Topaz is a service that measures call center transaction response times. This tool is useful to CMS to measure the true response time of a CSR at a call center. One PC per call center with the minimum requirements of an NGD Personal Computer will be required to be available at each call center to run simulated transactions. CMS will work closely with each call center on the initial set up of the PC beyond that of normal NGD PC. The NGD team will provide further guidance on the overall process once Topaz is installed.

h. Contractors using NGD will periodically be required to participate in NGD User Group calls for NGD updates and/or to provide input on suggested changes.

i. Contractors deploying NGD need to plan for five additional days of NGD training/workshop to be held at central location for the purpose of identifying any business process changes that need to be implemented.

2. Publication Requests

Contractors using the NGD should order publications using desktop functionality. NGD operational procedures for publication ordering can be found at the Medicare Beneficiary Telephone Customer Service web site, http://www.cms.hhs.gov/callcenters/. (Note: Procedures are in development and will be posted at this site when completed).

3. Medicare Participating Physicians and Suppliers Directory (MEDPARD)

Contractors using the NGD should order the MEDPARD information using desktop functionality. NGD operational procedures for ordering the MEDPARD directory can be found at the Medicare Beneficiary Telephone Customer Service web site, http://www.cms.hhs.gov/callcenters/. (Note: Procedures are in development and will be posted at this site when completed)

4. Guidelines for Telephone Service

a. In any situation where CSRs are not available to service callers or the call center is experiencing reduced beneficiary customer service due to diminished answering capacity, CMS plans to re-route call traffic within the national network to ensure that callers receive the best possible service. These situations include, for example, emergency and weather-related closings, training closings, and other deviations from their normal hours of operation.

b. The contractor shall follow standard operating procedures (SOP) to identify and address situations that will require action by the contractor to notify CMS to re-route beneficiary calls. The SOP will include the various procedures call centers must follow including whom to contact, when to contact, etc.

c. When a determination is made whether to close a beneficiary call center due to emergency or weather-related circumstances, the contractor shall consider whether it is also closing other co-located Medicare operations (e.g., medical reviews, claims processing, provider operations, appeals, MSP, etc). As a general rule, if other co-located Medicare operations are open, the beneficiary call center should be open.

d. Under no circumstances shall a beneficiary call center close to avoid a negative impact on call center performance statistics or to staff provider call center operations.

5. Automated Services-Interactive Voice Response (IVR)

All beneficiary premise-based IVR services provided by the contractor will be discontinued at the time the contractor migrates to 1-800-Medicare. This also includes features such as "auto attendant" or "vectoring" where callers can opt to make a selection to listen to an announcement (such as a message concerning a lost Medicare Card) to have their question answered. All calls routed to beneficiary call centers shall be handled directly by a Customer Service Representative (CSR).

6. Initial Call Resolution

Contractors handle no less than 90 percent of the calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR.

7. Call Handling Requirements

a. Sign-In Policy: Other support staff assigned beneficiary telephone workload should follow the same sign-in policy as CSRs to ensure data consistency.

b. Implementation by CMS of various services and technologies (e.g. single 800 number, network IVRs, network call routing) may result in modifications to some call handling requirements. For example, queue messages may be delivered in the network rather than by the premise-based equipment. As these transitions occur and changes are necessary to these requirements, CMS will provide instructions to those contractors impacted at the appropriate time.

8. Single 1-800-Medicare Standardized Procedures/Training

Standardized business procedures and training for the Single 1-800-Medicare initiative will be posted on the Medicare Beneficiary Telephone Customer Service web site, http://www.cms.hhs.gov/callcenters/. Contractors should access this site monthly for updates.

9. Customer Service Assessment and Management System (CSAMS) Reporting Requirements--Data to Be Reported Monthly

a. In those rare situations where one or more data elements are not available by the 10th of the month, the missing data shall not prevent the call center from entering all other available data into CSAMS timely. The call center shall supply the missing data to CMS within two workdays after it becomes available to the contractor.

b. Note: Implementation by CMS of various services and technologies (e.g. single 800 number, network IVRs, network call routing) may result in changes to some of the data element definitions currently being reported as well as the potential elimination of others. As this transition occurs, every effort will be made by CMS to accommodate those call centers that have converted to the latest technology and those who have not converted. While the sources of the data may change, CMS will attempt to maintain the current definitions to the fullest extent possible.

10. CSR Training

Call center managers should subscribe to the call center Listserv by going to http://list.nih.gov/archives/cam-callcenters.html. The Listserv subscribers will be notified directly through E-mail regarding new and updated training, scripting, and/or frequently asked questions and answers regarding the Medicare Modernization Act.

11. Hours of Operation

While there are no required standard hours of operations for beneficiary call centers, the preferred normal business hours for CSR telephone service continues to be 8:00 a.m. to 4:30 p.m. for all time zones of the geographic area serviced, Monday to Friday. Contractors are expected to respond to all beneficiary telephone calls routed to them up to the end of their business day. Contractors must not stop taking calls prior to the end of the business day in order to eliminate calls waiting in queue.

12. Telephone Service for the Hearing Impaired

a. Beginning in FY 2005 all beneficiary Telephone Services for the Deaf/TeleTYpewriter Service (TDD/TTY) calls will be routed to 1-800-Medicare call centers. At that time, contractors should modify their MSNs to replace their TDD/TTY number with CMS' branded TTY/TDD toll-free number, 1-877-486-2048. Standard operating procedures (SOP) will be developed to address those occasions when Medicare contractors are needed to work with the 1-800-Medicare contractor to respond to beneficiary callers that require additional assistance.

b. The migration of all TDD/TTY traffic to 1-800-Medicare call centers will eliminate all reporting requirements associated with the contractor's premise-based TDD/TTY service. This will also eliminate the requirement that the monthly Incompletion Rate (also known as the All Trunks Busy (ATB) External Rate) shall not exceed 20% for any beneficiary call center's TDD/TTY service.

Workload

Beneficiary Telephone Inquires workload (Workload 1) is the cumulative inquiries as reported on the CMS-1566, Line 35, Beneficiary Column.

Beneficiary Written Inquiries (Activity Code 13002)

The instructions for handling beneficiary written inquiries are described in Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2-Beneficiary Customer Services, Section 20.2 – Guidelines for Handling Written Inquiries. Also refer to the Activity Dictionary (Attachment 1 to the BPRs) for the lists of tasks for this activity.

Please note the following additions/revisions to the current manual instructions.

Date Stamping

The Medicare contractor will date-stamp the cover page of the incoming letter and the top page of each attachment. The contractor may continue to Date Stamp the envelope if it currently does so. However, date stamping the envelope is not required.

Fogging

In an effort to provide consistency to the Fogging process, all Medicare contractors shall use the Gunning Fogging method. This is the same clarity tool that CMS uses in Contractor Performance Reviews. Please see the Attachment A to the Beneficiary Inquiries BPRs for a copy of the Fogging Calculation Worksheet. Those contractors using standardized paragraphs provided through NGD are not required to fog those paragraphs.

Workload

Written Inquiries workload (Workload 1) is the cumulative written inquiries as reported on the CMS-1566, Line 37, Beneficiary Column. Workload 2 is the cumulative visitor inquiries (formerly walk-ins) as reported on the CMS-1566, Line 36, Beneficiary Column.

Walk-In Inquiries (Activity Code 13003) - Deleted

In recent years, CMS has directed contractors not to publicize their walk-in function. The number of walk-in inquiries is a very small activity compared to beneficiary telephone/written inquiries.

Therefore, CMS has decided that all current manual instructions/requirements for beneficiary walk-in inquiries will be deleted for FY 2005. With the deletion of the contractor requirements, there will be no separate funding provided for beneficiary walk-ins in FY 2005. Additional funding for visitor inquiries has been included in Written Inquiries (13002). CMS does expect contractors to be courteous and responsive to any visitors coming to the contractor's facility. Costs incurred and workload involved with servicing visitors should be reported under Activity Code 13002 – Written Inquiries.

Customer Service Plans (Activity Code 13004)---(Include your annual CSP and costs for CSP activities in your FY 05 budget request)

FY 2005 national funding will continue at the same funding level as in FY 2004. Individual contractor funding levels will be determined at the RO level. Contractors who wish to perform CSP activities in FY 2005 should submit an annual CSP to their Associate Regional Administrator for Beneficiary Services in accordance with current manual instructions. All remaining CSP contractor instructions remain in effect.

Beneficiary Internet Web Sites

Contractors that maintain a web site for Medicare beneficiaries on the Internet are required to ensure that information posted is current and does not duplicate information posted on the Medicare.gov website maintained by CMS.

Second Level Screening of Beneficiary and Provider Inquiries (Activity Code 13201):

Refer to PIM Chapter 4, §4.6-4.6.2 for instructions on this Activity Code.

The Medicare fee-for-service contractor reports the costs specified below that are associated with second level screening of potential fraud and abuse inquiries for beneficiaries and the referral package for provider fraud and abuse inquiries in Activity Code 13201.

For beneficiary inquiries of potential fraud and abuse, report costs for the following:

- Second level screening of beneficiary inquiries that are received, resolved and closed.
- The number of medical records for beneficiary inquiries; and
- The number of potential fraud and abuse beneficiary inquires that are referred to the Program Safeguard Contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity Unit (BIU).

For provider inquiries, report the costs associated with compiling the referral package and sending it to the PSC or Medicare fee-for-service contractor BIU.

Report the number of second level screening of beneficiary inquiries that are open or closed (count the same complaint only once) in Workload 1; report the total number of medical records ordered for beneficiary inquiries that were open or closed (count the same complaint only once) in Workload 2; and report the total number of potential fraud and abuse beneficiary complaints identified and referred to the PSC or Medicare fee-for-service contractor BIU in Workload 3.

Second Level Screening of Provider Inquiries (Activity Code 13201/01)

The Medicare fee-for-service contractor must keep a record of the cost associated for all provider inquiries of potential fraud and abuse that are referred to the PSC or Medicare fee-for-service contractor BIU in Activity Code 13201/01.

Attachment A

BENEFICIARY INQUIRIES

Fog Calculation Worksheet

1.	Total Number of words	_____
2.	Total Number of sentences	_____
3.	Average sentence length (number 1 divided by 2)	_____
4.	Number of polysyllable words (3 syllables or more)*	_____ X 100 = _____
5.	Percent of hard words (number 4 divided by number 1)	_____
6.	Number 3 plus number 5	_____
7.	Reading level (number 6 X .4)	_____

- Do not count words that are normally capitalized, combinations of short, easy words, or verb forms, which result in 3 syllables by adding " ed", "ing", "ly", or "es". Count hyphenated words as separate words. Do not count numbers or words, which are part of the structure of the letter. Count numbers, abbreviations, and acronyms as one-syllable words. **Except for exclusions noted above, no other exclusions are permitted.**

NOTE: If a date is included in the body of the letter, the entire date will be counted as 1 word.

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Provider Communications (PCOM)(Intermediary)

The aim of Program Management Provider Communications (PM-PCOM) for FY 2005 continues to be based on CMS' goal of giving those who provide service to beneficiaries the information they need to: understand the Medicare program; be informed often and early about changes; and, in the end, bill correctly.

The PM-PCOM Budget and Performance Requirements (BPRs) activities in FY 2005 will again center on electronically communicating to providers information on Medicare programs, policies and procedures. The remaining provider communications work will be funded through the Medicare Integrity Program (MIP) budget.

The Provider Communications instructions in the Contractor Beneficiary and Provider Communications Manual, Pub.100-09, (Chapter 4, Section 20) represent the current requirements for Fiscal Intermediaries. This BPR identifies new and incremental work proposed for FY 2005.

Activity Based Costing (ABC) will again be used in the budget process for Provider Communications. The Provider Communications work components from the Manual and both PCOM BPRs are grouped within and under the ABC definitions. The ABC dictionary is attached (Attachment 1 to the BPRs).

The following are the new PM-PCOM BPR activities for FY 2005:

Provider/Supplier Information and Education Website (Activity Code 14101)

Reference: IOM, Pub.100-09, Chapter 4, Section 20.1.7

Website Feature Enhancements

- Develop a working "Site Map" feature for your provider/supplier Medicare website. This feature would show in simple text headings the major components of your provider/supplier website and would allow users direct access to these components through selecting and clicking on the titles. This feature must be accessible from the homepage of the website using the words "Site Map. This feature must be operational by December 31, 2004.

- Develop a tutorial explanation of how to use your provider education website. This tutorial must be accessible from the homepage of your provider education website. The tutorial must describe to users how to navigate through the site, how to find information, and explain important features of your website. This tutorial function must be operational by December 31, 2004.

- Provide a means to allow providers/suppliers to offer reaction to CMS about your performance in their dealings with you. Use the mailing address of your CMS Regional Office PCOM Coordinator as the referral point for these reactions. This mechanism is to be located on your provider feedback instrument within your website.

Electronic Mailing Lists (listserv) (Activity Code 14102)

Reference: IOM, Pub.100-09, Chapter 4, Section 20.1.7

- Implement measures to actively market and promote to your provider/supplier community the advantages and benefits of being a member of your listserv(s). Use all your regular provider/supplier communications tools and channels (bulletins, workshops, education events, advisory group meetings, written materials, remittance advice messages, etc.) for this endeavor. The total of unique, individual active members of your listserv(s) must be at 50% or higher of your provider count by March 31, 2005, and 60% or higher of your provider count by September 30, 2005. Report your progress in achieving this including the current number of members of your list-serv(s), the number of unique members of your listserv(s) and the percentage of your provider count this represents in the PSP Quarterly Activity Reports in the "Other Activities" section.

Workload

Workload 1 is the total number of contractor provider/supplier PCOM electronic mailing lists.
Workload 2 is the total number of registrants on all the PCOM electronic mailing lists.
Workload 3 is the number of times contractors have used their electronic mailing list(s) to communicate with provider/suppliers.

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Provider Reimbursement

Intermediaries should ensure their budgets include appropriate funding to perform all provider reimbursement activities. In accordance with Activity Based Costing initiative (refer to the Activity Dictionary, BPRs Attachment 1) your funding should be reported to the following activity codes:

Non-MSP Debt Collection/Referral (Activity Code 16002)

Report all overpayment recovery costs (except MSP recovery cost) in Activity Code 16002. This includes the following activities related to debt collection, debt referral, extended repayment plan requests, etc:

1. Promptly suspend payments to providers in accordance with 42 CFR 405.370 to help assure the proper recovery of program overpayments and to help reduce the risk of uncollectible accounts.

2. Verify Bankruptcy information for accuracy, timeliness, and coordinate with CMS/OGC to ensure proper treatment and collection of any overpayments to the Trust Funds.

3. Record overpayments determined by functional areas timely.

4. Refer all eligible delinquent debt to Treasury within 180 days of the debt becoming delinquent. (Do not include MSP debt referral on this line.)

5. Promptly review all extended repayment plan requests. Coordinate with regional and central office on Extended Repayment Plans (ERPs) that are over 12 months.

6. Overpayment Recoupment Processing.

Note: The financial accounting and reporting associated with the actual overpayment recoupments will continue to be handled as an overhead cost. Overpayment development costs should be charged in the respective budget line from which they are generated.

Interim Payment Control (Activity Code 16003)

Report all Interim Payments activities in activity code 16003. This includes the following:

1. Closely monitor provider compliance with interim payment requirements, especially those providers reimbursed under the periodic interim payment (PIP) method of reimbursement, and terminate providers from PIP, when necessary, in accordance with 42 CFR 413.64 (h) and *42 CFR 412.116 (b) (c).*

2. Review Graduate Medical Education (GME), Indirect Medical Education (IME), Disproportionate Share Hospital, bad debt, and organ acquisition, etc. interim rates. Ensure its accurate computation in accordance with Medicare reimbursement principles.

3. Review documentation requests for special payment status such as sole community and Medicare dependent hospitals.

Workload

Report the number of provider interim rate reviews performed (include PIP reviews) in Workload 1.

Reimbursement Report and File Maintenance (Activity Code 16004)

Report all reimbursement report and file maintenance cost in activity code 16004. This includes the following activities:

1. Maintain accurate PPS Pricer Prov (provider specific) file.

2. Ensure an accurate System for Tracking Audit and Reimbursement (STAR) database is maintained, including ensuring that all information is properly entered and reported.

3. Maintain the Provider Statistical and Reimbursement (PS&R) system including testing all system updates and ensuring data is reliable for cost report settlements.

4. Obtain cost reports from providers including issuing cost report submission reminder letters, PS&R reports, and demand letters.

5. Update file for cost-to-charge ratios including mass updates – (Note - Calculating cost-to-charge ratios requiring audit/review activities should be charged to the appropriate provider audit activity code.

6. HCRIS – generate and submit HCRIS files.

7. Update provider specific files for all payment factors, e.g. DSH, IME, CCR, etc.

8. Calculate and notify providers of applicable rates, limits and caps (e.g. TEFRA, ESRD, Hospice, etc).

9. Answer information requests from CMS, OIG, DOJ, FBI, and GAO including FOIA requests related to reimbursement activities.

Workload

Do not report workload this activity code.

Provider-Based Regulations - (Activity Code 16005)

Carry out all functions in accordance with 42 CFR 413.65 related to making provider-based determinations. These activities include:

- processing all provider applications or attestations
- reviewing all applications or attestations for completeness and accuracy
- making any necessary on-site visits
- carrying out random sample reviews of providers that have not submitted any attestations or applications
- taking any necessary review or audit steps to allow CMS to make final provider-based determinations

Intermediaries should follow the instructions in CR 2411 for implementing the provider-based rules.

Workload

Report the number of recommendations for approval made to the regional office in Workload 1. Report the number of recommendations for disapproval made to the regional office in Workload 2. Report the number of attestations received (but for which recommendation to the regional office have not been made) in Workload 3.

Productivity Investments (Intermediary)

HIPAA EDI Transactions (Activity Code 17004)

The following is provided for informational purposes only, and should not be included in the Budget Request. Funding will be supplied for these activities when the instructions are issued, and you are directed to submit funding requests.

- Support for submitter testing for the 270/271.
- Implementation of new expanded EDI agreement.
- Implementation of the UB-04.
- Enforcement of the Administrative Simplification Compliance Act (ASCA) requirement that almost all initial claims be submitted to Medicare electronically.
- Elimination of issuance of most paper remittance advice notices.

Separate funding will be supplied upon release of any further instructions in FY 2005 that affect tasks under 17004 which are not included in the Bills/Claims Payment ongoing activities under Activity Codes 11201, 11202, and 11203.

Provider/Supplier Enrollment (Intermediary)

Provider/Supplier Enrollment (Activity Code 31001)

Provider/supplier enrollment (PSE) is a critical function to ensure only qualified healthcare organizations and entities are enrolled in the Medicare program. Healthcare organizations and entities must enroll with intermediaries, with whom they will do business, before receiving reimbursement for services furnished to Medicare beneficiaries. Each applicant will use the appropriate enrollment form and undergo the entire enrollment process, including verification of all of their information.

CMS has made it a priority to establish a strong link in its budget requests between program outcomes and contractor administrative funding levels utilizing the concept of Activity Based Costing (ABC). The ABC initiative is to identify and trace all material costs incurred when providing a service, e.g., Provider Enrollment, back to the activities that produce that output. The attached Activity Dictionary (Attachment 1 to the BPRs) lists "tasks" for the provider enrollment function; however, they are not to be considered an all-inclusive list of tasks performed under the PSE function. In addition to satisfying all requirements contained in the Provider Enrollment BPRs the Activity Dictionary, intermediaries are to budget according to the Medicare Program Integrity Manual, Chapter 10; other referenced manuals; and any applicable general instructions.

Workload Reporting Requirements (Cumulative)

Workload 1 – Initial applications (CMS-855A) and buyer CHOWs received.
Workload 2 – Changes of information (including seller CHOWs) received.

Other issues

- Intermediaries must justify all provider enrollment budget requests in writing.

- In general, provider enrollment-initiated educational activities will be charged to provider enrollment, e.g., phone calls, letters, and site-specific visits with suppliers, etc. Time associated in working with MIP-Provider Communications (PCOM) staff at seminars, conferences, etc. or through other MIP PCOM initiated resources, e.g. a bulletin, is to be charged to MIP PCOM.

- Intermediaries should assign staff to correspond with the enrollment workload in order to meet processing time requirements while still effectively screening applicants.

- There is a separate activity code to report the cost and workload associated with provider based entities (Activity Code 16005). Provider Enrollment should only be charged for the review of the CMS-855A application.

- Intermediaries should budget for and plan to attend a provider enrollment conference in 2005.

- Intermediaries are only responsible for the verification of the bank account in an Electronic Funds Transfer (EFT) situation, as well as any mailing costs associated with sending it out in the new provider package. The mechanical part of setting the EFT up must be reported under Activity Code 11201.

For Informational Purposes Only

- Intermediaries may have to respond to provider inquiries about the National Provider Identifier (NPI). Frequently Asked Questions will be provided before the NPI is rolled out.

- The web-enabled application is planned for the late summer of FY 2005. This activity will go through the change management process and include all details that you will need for making budget decisions.

Provider Inquiries (Intermediary)

The Centers for Medicare & Medicaid Services' (CMS) goal is to continuously improve Medicare customer satisfaction through the delivery of accurate, timely and consistent customer service. The CMS' vision is for customer service to be a trusted source of accurate and relevant information that is convenient, accessible, courteous and professional.

Every member of the customer service team shall be committed to providing the highest level of service to Medicare providers. This commitment shall be reflected in the manner in which you handle each provider inquiry. The following guidelines are designed to help contractors to ensure CMS' goal and vision are met.

Answering Provider Telephone Inquiries (Activity Code 33001)

IOM, Pub. 100-9, Chapter 3, §20.1

NOTE: All Equipment and Maintenance Costs shall continue to be reported under Code 33001.

1. Effective with these BPRs, the definition for Customer Service Representative (CSR) productivity will be changed to read "*CSR Productivity is the average number of calls handled by each CSR (calculated FTE) per month.*"

2. Those call centers having separate CSR and Interactive Voice Response (IVR) lines shall track and report the following information:

    - Number of Attempts for the IVR only line.
    - Number of Failed Attempts for the IVR only line.

    These data points will be used to determine the completion rate for the IVR only lines.

3. In FY 2003, CMS mandated that all contractors shall provide CMS the capability to remotely monitor provider calls. The following requirements clarify how the remote monitoring system shall be set up. CMS monitoring personnel shall have the capability to monitor provider Medicare calls by:

    - Specific workstation (CSR);
    - Next call from the network or next call in the CSR queue; or
    - By specific business line (Carrier, Fiscal Intermediary, or DMERC).

    If this capability does not presently exist, then the contractor shall develop a detailed cost

breakdown--including necessary hardware and software--for installing the capability as described above. The developed cost estimate shall be submitted with the contractor's FY 2005 budget request. Contractors shall not take any steps to procure or install new remote monitoring equipment without prior approval from CMS. CMS will assume those centers that do not submit a detailed cost estimate for this item currently meet the requirement and do not need additional funding to comply.

4. In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all call centers shall provide the ability for deaf, hard of hearing or speech-impaired providers to communicate via TeleTYpewriter (TTY) equipment. A TTY is a special device permitting, hard of hearing, or speech-impaired individuals to use the telephone, by allowing them to type messages back and forth to one another instead of talking and listening. (A TTY is required at both ends of the conversation in order to communicate.) Call centers currently having the ability to provide this service for beneficiary callers may use the same equipment, however, they may not use the same inbound lines. Contractors shall follow the process outlined in IOM, Pub. 100-9, Chapter 3, §20.1.1.B to request additional lines to handle this requirement. Contractors shall publicize the TTY line on their websites.

   If this capability does not presently exist, then the contractor shall develop a detailed cost breakdown--including necessary hardware and software--for installing the capability as described above. The developed cost estimate shall be submitted with the contractor's FY 2005 budget request. CMS will assume those centers that do not submit a detailed cost estimate for this item currently meet the requirement and do not need additional funding to comply.

5. For claims status inquiries handled in the IVR, all call centers shall authenticate the caller using at least the following information:

   - Provider number
   - HIC number
   - Date of service

6. Call centers may limit the number of issues discussed during one phone call, but all call centers shall respond to at least three issues before asking the provider to call back.

7. All contractors' IVRs shall provide definitions for the 100 most frequently used Remittance Codes as determined by each contractor. Contractors are not limited to 100 definitions and may add more if their system has the capability to handle the information.

   If this capability does not presently exist, then the contractor shall develop a detailed cost breakdown--including necessary hardware and software--for installing the capability as described above. The developed cost estimate shall be submitted with the contractor's FY 2005 budget request. CMS will assume those centers that do not submit a detailed cost estimate for this item currently meet the requirement and do not need additional funding to

comply.

8. All call centers with separate IVR only lines shall complete at least 95% of calls on these lines.

9. When a call center routes calls to another site, CMS needs to make sure that the contractor handling the calls gets credit for the work. If a call is forwarded over a contractor's system there is no way for CMS to determine the final termination point of the call. Therefore, prior to transferring calls to another center (including the Deployment Assistance Center (DAC)), contractors shall notify CMS through the Service Reports mailbox at servicereports@cms.hhs.gov. Contractors shall also notify the appropriate Regional Office.

10. Contractors shall answer no less than 85 percent of callers who choose to speak to a customer service representative within the first 60 seconds of their delivery to the queuing system. This standard will be measured quarterly and will be cumulative for the quarter.

11. Each CSR line shall have a completion rate of no less than 80 percent. This standard will be measured quarterly and will be cumulative for the quarter.

12. Contractors shall handle no less than 90 percent of calls to completion during the initial contact with the CSR. This standard will be measured quarterly and will be cumulative for the quarter.

13. Next Generation Desktop (NGD)

    a. Those contractors who will be deploying NGD in FY 2005 must include NGD implementation costs in their FY 2005 budget request in Activity Code 33001. These costs shall also be reported using Miscellaneous Code 33001/01 so that they can be identified separately as NGD implementation costs.

    b. CMS is standardizing some of the business processes for the users of NGD to facilitate consistent customer service performance, reporting and training. Standardized NGD business procedures will be posted on the Medicare Beneficiary Telephone Customer Service website, http://www.cms.hhs.gov/callcenters/. Contractors using NGD are required to train and use these procedures within 30 days of posting. Contractors should access the website monthly for updates. Training for the standard procedures is being developed by CMS and will be distributed to the contractors as developed. The training will be incorporated into the CMS NGD training package on a quarterly basis.

    c. A Deployment Assistance Center (DAC) has been established to support call centers during NGD implementation. The DAC is staffed with CSRs trained to handle Medicare inquiries from all lines of business. Certain functions may need to be transferred back to the site, however, it is expected the sites deploying NGD will utilize the services provided by the DAC prior to requesting any performance waivers. During the period of implementation, CMS will work with the contractor to determine the

support needed from the DAC and relax performance standards where it is still deemed appropriate.

d. Local Site Administration - Several administrative functions will be performed at the call center level by contractor personnel. Two to three days of mandatory training on these functions will be provided by NGD trainers at a central location.

e. Each contractor will be expected to operate a local help desk (Tier One) for NGD. The NGD trainers will provide a two-day training course for helpdesk personnel at a central location.

f. Security and Connectivity Issues: Technical Kick-off Meeting - Contractors deploying NGD will be required to send technical representation to a two-day technical kick-off meeting conducted by NGD infrastructure personnel in a central location. This meeting will take place prior to beginning the project plan to deploy NGD. Once all needed connectivity is obtained, an official deployment kickoff meeting will take place to begin the rollout of NGD to the contractor location(s).

g. Mercury Topaz - Mercury Topaz will be installed on one Personal Computer (PC) at each call center location prior to the rollout of NGD. Mercury Topaz is a service that measures call center transaction response times. This tool is useful to CMS to measure the true response time of a CSR at a call center. One PC per call center with the minimum requirements of an NGD Personal Computer will be required to be available at each call center to run simulated transactions. CMS will work closely with each call center on the initial set up of the PC beyond that of normal NGD PC. The NGD team will provide further guidance on the overall process once Topaz is installed.

h. Contractors using NGD will periodically be required to participate in NGD User Group calls for NGD updates and/or to provide input on suggested changes.

j. Contractors deploying NGD need to plan for five additional days of NGD training/workshop to be held at central location for the purpose of identifying any business process changes that need to be implemented.

Workload

Workload 1 is the cumulative inquiries as reported on the CMS-1566, Line 35, Column

Provider Written Inquiries (Activity Code 33002)

IOM, Pub. 100-9, Chapter 3, §20.2

1. Contractors shall send a final response to all provider written correspondence within 45 business days.

2. Contractors shall date-stamp the cover page of the incoming letter and the top page of each attachment.

3. Contractors shall not be required to keep the incoming envelope. However, if it is a contractor's normal operating procedure to keep envelopes with the incoming correspondence, the envelope, incoming letter and any attachments shall be date-stamped in the corporate mailroom.

4. Contractors shall not use "Dear Provider" in the salutation of the outgoing letter. They shall use the name on the incoming or the name in the contractors' systems.

Workload

Workload 1 is the cumulative number of provider written inquires received by the contractors as reported on the CMS-1566, Line 37, Provider Column.

Provider Walk-In Inquiries (Activity Code 33003)

IOM, Pub. 100-9, Chapter 3, §20.3

No changes.

Workload

Workload 1 is the cumulative inquiries as reported on the CMS-1566, Line 36, Provider Column.

Quality Call Monitoring (QCM) Performance Measures (Activity Code 33014)

IOM, Pub. 100-9, Chapter 3, §20.1.7

1. Of all calls monitored for the quarter, the number of CSRs scoring as "Pass" for Adherence to Privacy Act shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

2. Of all calls monitored for the quarter, the number of CSRs scoring as "Achieves Expectations" or higher for Knowledge Skills shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

3. Of all calls monitored for the quarter, the number of CSRs scoring as "Achieves Expectations" or higher for Customer Skills Assessment shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

Staff Development and Training (Activity Code 33020)

IOM, Pub. 100-9, Chapter 3, §20.1.6

No changes.

Second Level Screening of Provider Inquiries (Miscellaneous Code 13201/01) (PIM, Chapter 4):

The Medicare fee-for-service contractor must keep a record of the cost and workload associated for all provider inquiries of potential fraud and abuse that are referred to the Program Safeguard Contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity Unit using Activity Code 13201 in the Beneficiary Inquiries function.